 NTIS #PB 88-240163

NATIONAL HOSPITAL PROSPECTIVE PAYMENT EVALUATION

CASE STUDY SITE REPORT

WESTERN NORTH CAROLINA

November 10-14, 1986

REPORTS
RA
971
.32
N385
1986
[no.7]

Team Members:

Ann Hendricks
David Kidder
Lynn Barth

This research was supported by Contract No. 500-85-0015 Work Assignment No. 10: Case Studies of the Impact of the PPS, from the Health Care Financing Administration. The views and opinions expressed in this report are the contractor's and no endorsement by HCFA or DHHS is intended or should be inferred.

Abt Associates Inc. 55 Wheeler Street, Cambridge, Massachusetts 02138 TELEPHONE (617) 492-7100
Health Economics Research, Inc. 75 Second Avenue, Suite 100, Needham Massachusetts 02194 TELEPHONE (617) 444-8910

RA
971.32
.N385
1986
[no.7]

TABLE OF CONTENTS

		Page
1.0	**OVERVIEW OF WESTERN NORTH CAROLINA**	1
2.0	**SCOPE OF INTERVIEWS**	4
3.0	**HOSPITAL MARKET STRUCTURE AND RESPONSES TO PPS**	6
	3.1 Competitive Market Structure	6
	3.2 Hospital Performance	8
	3.3 Changes in Hospitals' Conduct Over the Last Five Years	9
	3.3.1 Lowering Costs	9
	3.3.2 Price Competition	10
	3.3.3 Non-price Competition	11
	3.4 Reactions to PPS	12
4.0	**PPS AND ALTERNATIVE HEALTH PLANS**	16
5.0	**MEDICAL PRACTICE PATTERNS UNDER PPS**	17
	5.1 Patterns of Practice	17
	5.2 Hospital Admissions	18
	5.3 Lengths-of-Stay and Post-hospital Control	19
6.0	**THE POST-HOSPITAL HEALTHCARE INDUSTRY UNDER PPS**	20
	6.1 Hospital Involvement in Post-Hospital Care	21
	6.2 Hospital Discharge Planning	21
	6.3 Relationship of Discharge Planning to Community Agencies	23
	6.4 Home Health Agencies	23
	6.5 Nursing Home Administration	25
7.0	**PROGRAM OPERATIONS**	26
	7.1 Peer Review Organization	26
	7.1.1 Administration	26
	7.1.2 SuperPRO Ratings and HCFA Contracting	26
	7.1.3 Quality Assurance and Record Reviews	27
	7.2 Fiscal Intermediary	28
	7.2.1 PIP and CPEP	29
	7.2.2 HHAs and Record Review	29

PREFACE

This is one of ten site reports of case studies conducted between September and December, 1986, by staff members of Abt Associates, Inc. and Health Economics Research, Inc. under Contract No. 500-85-0015 to the Health Care Financing Administration (HCFA). The views expressed are our own and no endorsement by HCFA or the Department of Health and Human Services is intended or should be inferred. Each report is a summary of the facts and subjective comments from all participants at one of the ten sites.

This report characterizes the structures of parts of the health care industry (e.g., hospitals, nursing homes, home health agencies) in this site as they were perceived by members of the study team. Individual respondents and institutions are not mentioned by name, nor are they meant to be identifiable. We are interested in generalizing about the responses of the industry to the Medicare prospective payment system, not in pointing out any one type of response. We would like to raise the appropriate policy issues objectively and from all points of view. These issues can then be addressed in the statistical analyses of data on beneficiaries and providers, which in turn will be synthesized by HCFA staff into the Congressionally-mandated report about the impacts of the prospective payment system.

The ten site reports will not make up the report to Congress. The ten sites are not a scientifically representative sample of the nation's health care providers. Therefore, they are only illustrative of what is happening across the country. As such, they have already proven to be invaluable to the study staffs. The information and subjective opinions of the 500-600 respondents will be incorporated in the analyses of secondary data in five topic areas: hospital competition, alternative health plans, medical practice patterns, post-hospital care, and program operations. They are being used in developing hypotheses, exploring unexpected results and raising policy concerns.

We once again thank those many respondents who so generously gave us their time for the discussions that provided these insights. Special thanks are also due to the support staffs of Health Economics Research and Abt Associates for arranging the site visits and producing the reports, and to the secretaries of participating executives who coordinated the interviewing schedules in the field.

1.0 OVERVIEW OF WESTERN NORTH CAROLINA

The western border of North Carolina runs along the ridges of several mountain ranges, including the Great Smoky Mountains. The most western counties of the state are all fairly mountainous and are also blanketed by two national forests and a national park. Tourism and outdoor sports, such as skiing and hiking, are major economic activities in the area (rather like northwestern Vermont). In the summer, the altitude moderates the southern heat and there is an influx of residents, many of whom are elderly. The counties just west and south of Asheville, the major city in the region, are said to have summer populations 40 percent above those in the winter.

This case study site was chosen because it afforded relatively easy access to a large number of rural hospitals. In the 17 most western rural counties, there are 15 non-federal, short-term, acute-care hospitals. Eight are no more than an hour and a half from Asheville, five more lie farther into the mountains west of Asheville, and two are quite far to the east of the city.

Asheville is nestled in the middle of this area, between two arms of the Pisgah National Forest. It is roughly equidistant (60-75 miles) from Greenville and Spartanburg, South Carolina, to the south, and the Johnson City/Kingsport/Bristol area in Tennessee, to the north. Similarly, it is about halfway between Charlotte, North Carolina, 125 miles to the southeast and Knoxville, Tennessee, 100 miles to the Northwest. These competing urban areas must be kept in mind in examining the area's health industry.

In such hilly terrain, the most direct road between rural communities may not be the shortest either in terms of miles or time. This is especially true when the weather is bad and the mountain roads are hazardous. This means that some small rural hospitals are very important to their isolated communities, especially for emergency care. For more discretionary services, however, rural hospitals compete in a much wider area. Once drivers reach an interstate highway (I-26 or I-40) or a major state road (e.g., 23 or 221), travel conditions are excellent, subject to the weather, of course. This means that the hospitals in Asheville itself are competitive with rural hospitals in neighboring counties because they are only a 20-30 minute drive farther away.

Hospitals in western North Carolina are under increased competitive pressure due to declining admissions and shorter lengths of stay. Their responses have generally been to increase advertising, improve amenities, and diversify services rather than to lower inpatient charges. The relatively low level of price competition for hospital admissions may be due to the lack of pressure from area employers, to the relative absence of HMO activity, and to the already low costs in the region.

Price competition is greater for selected ancillary services and outpatient departments, however. Activity in the latter has expanded greatly at every facility, as is the case across the country. By keeping prices relatively low, hospitals are deliberately trying to keep various departments operating close to full capacity, or at least efficient scale.

Financially, the hospitals appear to be doing well under the PPS rate structure, but those receiving the urban Federal rates are doing far better than those being paid rural rates. The urban-rural rate differential was the subject of many comments, as a consequence. The Medicare capital pass-through is readily admitted to be a major factor for virtually all hospitals, because of recent building and renovations. However, neither profits nor losses can be attributed solely to PPS. The major commercial insurer pays charges, commercial rates have risen and other favorable changes have occurred. On the other hand, non-Medicare admissions are down, leaving several hospitals greatly underutilized.

All of the hospitals have taken steps to reduce or control costs through flexible staffing, converting unused inpatient space to other uses, using weekend surgery to speed up discharges, and so forth. In general, informal controls on physicians' practice patterns seem to have been effective in reducing lengths of stay and costs, and physicians prefer self-policing to PRO review. Also effective is discharge planning that focuses on the early identification of patients who will require post-hospital care. In many hosital, the discharge planners have increased latitude to identify, screen, and initiate plans for aftercare.

The effects of these changes can be seen in the post-hospital care industry. There appears to be a shifting of casemix among post-hospital care settings. Nursing home administrators report that recent referrals are older, more debilitated patients who require more care than referrals prior to PPS. This shift is a conscious attempt on the part of hospital discharge planners in some counties to ration scarce nursing home beds. Less disabled patients are now given home health services or referred to rest homes. This modifies the demand for nursing home beds, ensuring that some of the most debilitated patients are accepted.

This change in utilization patterns has strong financial implications. Under Medicare, services are reimbursible only when patients require skilled care and have rehabilitation potential. Administrators report that the Medicare intermediary has become much more stringent about enforcing the eligibility requirements. In the past the intermediary was likely to allow payment for the completely debilitated patients, but this has changed. One administrator commented that many patients whose services would have been paid for by Medicare in the past are now dependent on Medicaid, and the Medicaid payment for skilled care is not adequate. Consequently, nursing homes try to avoid or limit admissions of patients who are likely to require Medicaid payment.

Nursing home administrators complain of these changes while home care providers expect the demand for their services to increase. There are reported gaps in services for the elderly who do not require constant nursing care but who cannot live alone and for patients with chronic medical conditions. There is also a reported lack of homemaker resources for the elderly convalescents. However, in this area community-based volunteer services can be mobilized to fill some of the gaps.

Respondents at all levels (CEOs as well as discharge planners) are worried about the problems arising from earlier discharge. Other problem areas that were mentioned include the costs of frequent changes in the system, the outlier payments, payments for medical conditions involving

multiple systems, labor market definitions and the urban-rural rate differential, the annual updates, and removal of incentives inherent in the system.

On the other hand, respondents were generally in favor of the concept of PPS and other changes attributed to it. Many agree with the one who said, "I think it's a better system [than cost-based reimbursement]."

hospital, the discharge planner works with an RN patient care coordinator from the Home Care Department who assesses patients' nursing needs before they are discharged to any setting.

All reporting arrangements are to a central administrator of the hospital, although in one case the discharge planner reports to the administrator responsible for community services rather than to one responsible for internal operations.

In this site, many of the social work positions in hospitals are partially funded by the state Department of Social Services. This makes it possible for the social worker to have immediate access to Medicaid eligibility information as well as to other data that can facilitate post-hospital planning. This tie to the county system seems also to facilitate social workers' access to other community-based services for patients.

In all hospitals, it appears that the discharge planners are trying to get started earlier to identify needs and arrange post-hospital care. At one hospital, the admission form contains space to indicate referral for discharge planning. Three discharge planners report that formal criteria exist to identify high "at risk" patients. Examples include:

- Patients over 65 years old who live alone or with a frail care giver;
- Patients unable to give information at time of admission;
- Patients with terminal illness;
- Patients with increasing impairment;
- Patients with fractures or broken bones; and
- Patients with diagnoses of CVA, stroke, COPD.

One discharge planner reviews the Management Information System reports on new admissions daily, to identify potential clients. Others operate less formally, by reading charts of new admissions, talking to nurses, and, attending rounds. One hospital has a discharge planning committee, which meets weekly to identify patients needing services. In addition, all discharge planners accept referrals initiated by families, friends, and the patients themselves. The participation of the physicians varies among hospitals. Although the physician must always formally order post-hospital care, the level of actual involvement ranges from approving a plan developed by other staff to being responsible for actual initiation of any plan.

The process of actually planning for care appears consistent across hospitals. It is the responsibility of the discharge planner to be familiar with community services and to provide the physician and patient with alternative providers among which to select. In general, the patient or family selects the provider; if they cannot, the physician does, and in instances where neither chooses, the social worker recommends. (For nursing home placement, the choice of facility has to be balanced against the availability of a bed. Some patients are being asked to pay for the hospital care they use if they wish to wait for an available bed in the nursing home they select.) Almost all the social workers interviewed are responsible for coordinating services from

multiple agencies, if that is necessary. However, none of the discharge planners provide follow-up services after discharge, except in one instance where the social worker is assigned to the home care department half-time.

6.3 Relationship of Discharge Planning to Community Agencies

As noted earlier, several discharge planner positions are partially funded by the North Carolina Department of Social Services. This not only provides the discharge planner with quick access to the Medicaid eligibility process, and information on living conditions, but facilitates coordination with other community-based services, such as Meals on Wheels, chore services, transportation, etc.

Discharge planners report that the supply of home health services appears to be adequate. Problems are related more to the reluctance of families to accept it (for the reasons mentioned earlier) and the lack of payment for care. One agency has taken a very conservative approach to even applying for Medicare coverage for home health care--when in doubt, it uses grant funds to pay for care, rather than risk a denial for the services.

Almost all discharge planners commented that sufficient nursing home beds (for both skilled and intermediate care) are not available to meet the need. It is not clear to the discharge planners whether supply is inadequate or if other factors, such as the level of Medicaid payment for care or the reluctance of homes to accept more needy patients, are involved. Discharge planners are unanimous that the most difficult to place patients are those requiring total care, who have behavior problems, decubiti, or few social supports, or who are totally senile. One planner in a community hospital reports that of 13 patients needing nursing home placement in a three month period, more than half were placed immediately. The other six waited a total of 29 days; half of this waiting time was accounted for by just two patients. In contrast, another discharge planner in a tertiary care hospital notes that in a six month period, 21 patients waited a total of 1350 days for placement. A third hospital could not provide statistics, but reports that on any day six to ten patients are ready for transfer but are waiting for a bed.

6.4 Home Health Agencies

Five home health agencies were visited, including one that is hospital-based; two that are sponsored by the county health departments; one proprietary agency; and a hospice provider. The publicly-sponsored agencies service residents of the counties in which they are located; the proprietary agency serves patients from Buncombe County (Asheville) and a number of surrounding counties. All agencies receive many referrals directly from physicians' offices for patients who have not been hospitalized. One agency director estimates that several years ago it received about one-third of its referrals from physicians' offices; currently more than half of its referrals are patients who have not been hospitalized.

2.0 SCOPE OF INTERVIEWS

There are 23 hospitals in western North Carolina. Six are not covered by PPS: three are long-term care facilities, one is a VA hospital, one is for rehabilitation cases, and one specializes in alcohol dependency. Of the 17 short-term acute-care hospitals, two are urban and the rest are rural by HCFA's definition. Eight of these hospitals participated in the site case study: seven are rural hospitals; one, urban. Four hospitals are fairly small, each with 100 beds or less. Three have 150-200 beds and one has over 250 beds.

Fifty-nine people were interviewed over a five day period. Table 1 presents the number of interviews by topic area and the positions of the respondents. Sixteen interviews focused on hospital competition and related topics; 18 were concerned with the utilization of resources and patient management in the hospital; 17 were conducted in the post-hospital health care industry; and eight were with those involved in the operation of the state programs. There were no interviews with any representatives of alternative health plans.

To gain insights into the competitive environment of western North Carolina hospitals, eight chief executive officers were interviewed about their strategies and the relative positions of their hospitals under PPS and in the area's health care market. Information relating to price competition and financial standing was obtained in interviews with eight chief financial officers or hospital controllers.

In the area of utilization of hospital resources and patient management, the site team spoke with eight utilization reviewers, three DRG coordinators and seven chiefs of staff. For the aftercare industry, team members interviewed eight hospital discharge planners, administrators of three nursing homes and five home health agencies, and the director of the Agency on Aging. Interviews concerning program operations, were conducted with the director of the PRO office for western North Carolina, the director and two other managers of the state PRO, and four representatives of the fiscal intermediary.

TABLE 1

WESTERN NORTH CAROLINA SITE VISIT INTERVIEWS BY TOPIC AREA

	Hospital Competition	Utilization and Patient Management	Aftercare Industry	Program Operations
CEOs	8			
CFOs/Controllers	8			
U/R Coordinators		8		
DRG Coordinators		3		
Chiefs of Staff		7		
Discharge Planners			8	
PRO Administrators				4
Fiscal Intermediary Representatives				4
Nursing Home Administrators			3	
Home Health Agency Administrators			5	
Director of Agency on Aging			1	
Total Number of Interviews	16	18	17	8

3.0 HOSPITAL MARKET STRUCTURE AND RESPONSES TO PPS

Western North Carolina was chosen as a study site because it afforded relatively easy access to a large number of rural hospitals. The site team interviewed respondents in seven of the 15 rural, general hospitals. Understanding these rural hospital markets requires some understanding of the competition with urban hospitals as well. Interviews were therefore conducted in one of the urban acute-care hospitals.

3.1 Competitive Market Structure

Most of the rural hospitals in western North Carolina are the sole health facility in their counties and so have had geographic monopolies. Their market shares in their own counties have tended to be around 75 percent but current market conditions have lowered these shares to 60 to 70 percent. In these markets, there are strong bonds between many of the hospitals and their communities that allow the hospitals to maintain financial support but also make them answerable to local public opinion.

In the three counties that each contain two facilities, specialization has kept the hospitals from interfering too much with one another in the past. For example, in one county the Public Health Service Indian Hospital coexists with another small institution that serves the non-Indian population. In a second county, one tiny hospital offers emergency service and a few special facilities for its mountain community while births occur at the slightly larger institution down the road.

In these duopolies, market shares of individual hospitals have tended to be no more than about 50 percent. All of the executives interviewed, however, are well aware of competitive pressures from nearby rural hospitals (usually in the next county) and from the two large hospitals in Asheville. This latter pressure is not felt equally by rural hospitals surrounding the city. The farther south or east of Asheville a hospital is located, the more likely it is to refer to and compete with the urban hospitals in Greenville, Spartanburg, or Charlotte rather than Asheville. The rural hospitals west of the Metropolitan Area do not have as easy access to a second urban area (Knoxville, Tennessee) because of the drive over the Smoky Mountains. These administrators are more sensitive to perceived threats from Asheville. For example, some respondents spoke of "war chests," which the Asheville hospitals have supposedly amassed since PPS and which could finance marketing campaigns in rural areas.

No hospitals are proprietary institutions although some are managed by professional, for-profit chains. Two are controlled by county government boards, one is an Indian service facility and the others are all voluntary non-profit hospitals. Five of the 17 have ties to larger regional or national systems. These connections are important in giving those hospitals access to additional resources for management and for investment.

One hospital has been designated as a rural referral center and so should be expected to compete more directly with all three urban centers for some of the more complex cases. This hospital is larger than many of its rural neighbors and has a somewhat higher Medicare casemix index. About 30 percent of its cases come from outside its own county.

The rivalries of these hospitals and the strategies to which they give rise are discussed in Section 3.2.3 below. They have not yet resulted in any changes in the hospital market structures: no hospitals have closed, there is no formal or informal integration of any hospitals into larger networks (seen in other case study sites), only one hospital satellite was opened in a rival's market but it was repelled by the local physicians. However, some of these changes are being talked about as possibilities. Fears of rival's encroaching on rural markets may lead to some informal networking for referrals for specialized care.

There is only a little activity with respect to alternative health plans such as health maintenance or preferred provider organizations. Attitudes toward potential market penetration are mixed. Some would echo the respondent who thought that HMOs would stay primarily in the larger cities, such as Charlotte. Others might be in more agreement with the executive who is planning to be competitively positioned when HMOs or PPOs enter his market. These differences in attitude may, in part, reflect the hospitals' distances from the Charlotte market, where there are alternative health plans.

In the Asheville area, a Blue Cross HMO has gained acceptance in those area markets that contain larger numbers of state employees, for whom it is an insurance option. One regional hospital has started its own HMO but the HMO is "not likely to succeed," according to an executive in a competing institution, and so may not be seen as a threat. Reactions among physicians to these inroads vary from suspicion and little interest in alternative health models to definite interest in starting a plan as a joint venture with the local hospital. Not all of the hospitals are currently able to pursue these interests, however, because their financial structures (i.e., county-owned) do not permit joint ventures.

Legal constraints on hospital structure have limited the amount of financial reorganization within area hospitals. Many have protected themselves from potential loss of control with umbrella organizations, a fund-raising foundation, and the ability to diversify outside of traditional acute-care activities with hospices, home health agencies, nursing homes, and office buildings. In this they are in step with changes occurring in hospitals across the country since the early 1980s.

Unlike some other case study sites, Asheville is not experiencing great pressure from insurance companies to constrain costs. Several administrators attribute this to the fact that there are no national headquarters in the region. All large companies are branches of larger corporations. Compared to the costs of health care in the other areas of the country where the corporations operate, Asheville area hospitals are seen as a bargain. One hospital had held a special meeting of company representatives to uncover concerns and found no pressure to change

current practices. Companies were most concerned about worker's compensation cases and at least one hospital has been more active in this area.

Commercial insurance, Blue Cross, and employers with self insurance generally account for a third to half of each hospital's revenues. Medicare coverage is a half to a third of revenues in these same institutions (the proportion being inversely related to the amount covered by employers' insurance). Medicaid averages 3 to 8 percent of revenues. Self-pay varies from 5 to 11 percent. Bad debt is generally 7 to 10 percent across all hospitals. Both are reportedly related to the levels of household incomes in the counties where the hospitals are located.

Medicaid is not a great problem to rural North Carolina hospitals compared to other sites. A flat per diem is paid. It was pointed out that the state has limits on the Medicaid days covered in large hospitals, so the largest hospitals in the area (in Asheville) have the most problems with Medicaid coverage. All of the hospitals help patients to determine their eligibility and to complete and file the forms, if needed, but, again, this is not as aggressively pursued as in other sites.

3.2 Hospital Performance

The experience of western North Carolina hospitals under PPS has been mixed. Most have experienced a decline of roughly 10-25 percent in inpatient admissions and days between 1982/83 and 1985/86. However, at least one respondent reports stable levels of admissions during those same three years and one or two hospitals have had much more severe reductions in inpatient admissions.

Generally, hospitals report a greater decline in inpatient days than in admissions, therefore the average lengths of stay fell (by a half to one and a half days) during this period. Admissions and days have stabilized at most of the hospitals studied during the site visit, however. In a few hospitals they have even been increasing in 1986.

The decreases in admissions and days were not restricted to Medicare patients. In fact, a few respondents noted that Medicare admissions actually increased in their hospitals during the period of general utilization decline. This may be due to shifts in market share across hospitals, to increases in the elderly population in a few counties, or to some temporary influence (such as the weather) on the health of the elderly.

The more general declines are widely attributed to changes in admissions practices. In addition, reduced inpatient activity is offset by increased outpatient activity (especially ambulatory surgery) in western North Carolina hospitals, as it is elsewhere in the country. Outpatient admissions or procedures have reportedly increased anywhere from 40 percent to well over 100 percent in the last three years.

Financially, the hospitals in this site appear to do well under the PPS rate structure in the sense that Medicare patients generally add more to revenues than to costs. Outliers are only about one percent of cases

in the rural hospitals and the costs in these institutions (casemix-adjusted) are below the national averages, as area employers have already noted. This does not mean that all fare equally well under PPS. Officers in those hospitals receiving the urban Federal rates indicate that their total margins are "embarrassingly high" in the last two years. Others note some financial difficulty.

Neither the embarrassing profits nor the losses can be attributed solely to PPS. For example, one institution raised its charges two years ago before it won a change in status under PPS. The increase was justified at the time by a small annual loss and projections of greater losses to come. The change of status increased the PPS payment and with the general rate increase transformed the losses to robust total margins. On the other hand, several hospitals are experiencing annual losses, largely because of recent building and renovation programs. When the increased costs of depreciation and interest are added to the operating expenses, a moderate plus or small minus (due to declining admissions) can be turned into a large minus. The CFOs of these hospitals readily admit the importance of the PPS capital pass-through to their institutions. Without it, total margins would be worse.

Many financial officers are projecting losses on total margins in a few years, however. These projections assume fairly constant payment rates for PPS and other payors, and costs that increase at 4 to 9 percent, based on recent trends in inflation of supply prices, increased depreciation and interest costs, and wage increases. As in other sites, these projections are fueling the search for new market niches to replace the old geographic monopolies or duopolies.

3.3 Changes in Hospitals' Conduct Over the Last Five Years

The term conduct denotes behavior and strategy on the part of firms in a market. Examples include changes that lower costs or alter prices, and forms of rivalry, such as advertising. Lowering costs will increase profits or lower losses even if market shares do not change. Price reductions and non-price rivalry are both ways in which firms compete for market share.

3.3.1 Lowering Costs

With falling admissions, hospitals need to reduce resource use even more sharply to reduce actual costs per admissions. Most of this cost reduction is being achieved across the country by shortening the lengths of stay for inpatients. This reduces the number of employees needed per patient and, consequently, the cost. In western North Carolina, these reductions have resulted in layoffs of hospital staff between 1984 and 1986. The layoffs vary from zero percent, where admissions have not declined, to perhaps over 25 percent in one hospital. The reductions were sometimes traumatic but efforts were made to minimize this. For example, because outpatient departments expanded, some support personnel could be transferred.

All of the area's hospitals reportedly use flexible staffing to control labor costs when daily censuses fluctuate widely. Labor needs are assessed daily and at least one hospital will send unneeded employees home on an unpaid vacation, as required. These measures are necessary to control labor costs in an area that reports annual wage increases of three to eight percent in each of the last two or three years and increases in benefits averaging above these rates.

The wage increases are said to be due to several factors. North Carolina is not economically depressed and the western region is reportedly highly unionized with wage levels that are generally high compared to adjacent regions or states. In some counties, the hospitals have given only a cost of living increase. However, in other counties there is said to be a shortage of registered nurses and hospitals have raised some nursing wages and paid finders' fees to ensure adequate staffing. In addition, executives say that the increased acuity in inpatient cases has strained their professional staffs and they feel that they must compensate for this with raises.

The second major area for cost containment is the reduction of fixed costs associated with empty beds. Fixed inpatient costs could be reduced if space were converted to outpatient services or other facilities as the hospitals diversify their service markets (see Section 3.3.3 below). This strategy cuts two ways, however. Removing space from inpatient use would reduce costs but it would also reduce the PPS payment by means of which capital costs are passed through.

The current capital payments are made according to the proportion of the hospitals' admissions that are Medicare. If 50 percent of admissions are Medicare, 50 percent of the inpatient capital costs in a base year are paid by the Federal government. This is a major benefit to hospitals that have all undertaken major building programs in the last five years. Decisions to remove inpatient space from this pass-through are made only after very careful consideration.

Other methods for containing costs in the area's hospitals include the use of formularies for hospital pharmacies (not a new practice since PPS); the substitution of less expensive supplies; and weekend surgery to speed up discharges. This last change is limited by the availability of anesthesiologists. None of these changes is seen as having a major impact on costs.

3.3.2 Price Competition

There is little price competition for routine care in the Asheville area. The penetration of alternative health plans is limited and likely to remain so for some time. There is no pressure from commercial and self-insurers to give discounts because the area has relatively low costs by national standards. Blue Cross pays charges.

Nevertheless, many of the hospitals have held room charges constant over the last few years. This may be due in part to their relatively healthy finances which do not support a need for rate increases. It also reportedly demonstrates the power of local boards of trustees who look

askance at every move to raise rates although they do not attempt to lower them. In a few instances, rates were raised because of projected losses. One hospital that believes it has the lowest charges in the local area has raised them by about 6 percent in the last two years. At least two others have raised charges more than that, but one did not need to, in retrospect, because its PPS status was subsequently changed and its PPS rate increased.

More price competition is reported for ancillary services, especially laboratory tests and x-rays. At least two rural hospitals have reduced their ancillary rates to increase their shares of the laboratory business. They feel the strategy has worked and is responsible for keeping their departments working close to capacity. A third hospital has kept its ancillary charges constant to remain competitive while other hospitals have been promoting specific services (such as mammography) as part of their marketing strategies and, consequently, charge only a low fee for the advertised "special."

3.3.3 Non-price Competition

There is intense non-price competition among western North Carolina hospitals. Virtually all of the hospitals visited as part of the case study (urban and rural), had rebuilt, renovated, or otherwise improved their facilities for physicians and amenities for patients in the last five years. These changes preceded PPS, at least with respect to the investment plans. However, the post-PPS competitive environment has had an impact on the use of the new facilities, their financing, and plans for additional investment.

The non-price rivalry of North Carolina hospitals centers on diversification into new product lines. A respondent in another site visit pointed out that there are eight services that are currently considered to be the most advantageous lines of expansion within a fairly traditional model of hospital activities. These are being considered by North Carolina hospitals and include:

- Cancer programs;
- Emergency room services;
- Cardiology;
- Pulmonary;
- Outpatient departments;
- Wellness or fitness programs;
- Women's health centers;
- Home health services.

North Carolina hospitals are reported to be expanding along one or more of these lines as well as considering opening units that are exempt from PPS such as psychiatric, alcohol or drug dependency, or rehabilitation units.

These latter services are all offered in Asheville or Buncombe County. When asked whether this fact did not diminish the attraction of yet another alcohol dependency unit to potential patients, one rural-based executive responded, "Most of the population around here is [in Buncombe County]. People want to go out of town to dry out." If this assessment is correct, there may soon be a flurry of activity in some of these product offerings in the region.

In all competitive undertakings, rural hospital executives in western North Carolina keep one eye on their rural neighbors and another on the activities of the urban Asheville hospitals. Their concern about the latter is two-fold: the rivalry between the two Asheville acute-care hospitals and potential for either to expand into rural hospital markets.

Both Asheville hospitals are non-profit institutions. The unaffiliated teaching hospital is 30 to 40 percent larger in terms of beds or inpatient admissions than its church-affiliated rival. They are literally across the road from one another. Their medical staffs have privileges at both but have generally chosen one or the other as their primary location for admissions. Sometimes this has resulted in the concentration of certain types of practice or service in one hospital or the other. For example, urologists and psychiatrists are said to admit mostly to one of the hospitals while ophthalmologists, cardiologists and obstetricians are concentrated at the other. However, physicians have reportedly held their ability to switch their admissions from one to the other hospital over the heads of both hospitals' administrators and, consequently, obtained amenities and additional facilities from both.

The specialization of these two hospitals might make it appear that the two area giants have agreed not to compete. Such is not the case. They are toe-to-toe (according to some) with respect to emergency room service, an application for a 60-bed long-term care unit, and for general admissions, among others. The rivalry appears to have intensified in the last few years with expansion and renovation first on one side of the street, then on the other.

The strategies of the two differ markedly, according to one of the two chief executives. His strategy is to stress programs while his rival is reportedly courting the Medicare population. This is confirmed by the images of the two hospitals held by several rural administrators. The Asheville hospital seeking Medicare business explicitly is seen in rural areas as being more of a community hospital with a long-standing reputation for excellent nursing and good patient relations but without the broad scope of services available in the rival institution. This rival has not been well-regarded for patient care in the past but this reputation has improved in the last two years; further, 80 percent of referrals from many of the area's rural hospitals to Asheville reportedly go to this second hospital because of its specialists and services.

This pattern of rural referrals differs by location around Asheville. Hospitals to the east and/or south also refer to Charlotte

and Greensboro hospitals. Charlotte is probably the bigger rival in this regard. A hospital there competes directly with the trauma center in Asheville and both have helicopters for rapid transport in this mountainous region.

Despite the patterns in many rural communities of referring primarily to the larger of the two Asheville hospitals, this institution is reportedly perceived as more of a threat to the rural hospitals than its urban rival. This seems at odds with the image of the latter (in the eyes of some) as a community hospital, larger but not all that different from the rural facilities. Nevertheless, the focus on one hospital as the threat from Asheville evinced itself in several ways. A few administrators mentioned advertising in their markets on the part of the urban hospital; others reported there was a large "war chest" amassed under the PPS urban rates to be used in future campaigns for rural markets; still others suggested that if patients with complex conditions could not be treated in the local rural institution, they should be referred to specialists far away (e.g., Durham) because then the local rural physicians would "get them back."

These predatory designs are denied in Asheville, where rural hospitals are reportedly viewed as important secondary care facilities, feeding complex cases to the area's tertiary facility. The existence of a "war chest" is steadfastly denied. While total hospital margins are admitted to have been exceptionally high, they have reportedly been used to finance hospital improvements. There is some discussion of building informal networks with rural hospitals and the suggestion that urban physicians should build reciprocal referral patterns with doctors in rural institutions. The slowness with which this potential vertical and horizontal integration appears to be taking place (compared to another case study, at least) may be due to the lack of competition for tertiary care in this area. If the second Asheville hospital were to develop its tertiary facilities, local networks of rural and urban hospitals might rapidly be an important outcome.

3.4 Reactions to PPS

Hospital respondents were generally in favor of PPS and other changes attributed to it. Their comments tended to be:

> "I think it's a better system [than cost-based reimbursement]."

or

> "I think the system is doing some things right."

Even physicians (in other areas, the group most against the change) would say:

> "I can practice medicine under the system we have now."

or

> "Doctors understand that the ones footing the bills have to know more about what's going on."

However, as can be expected in case studies of this type, most compliments have a negative clause appended. For example:

> "There was a lot of fat in the industry. It (cutting the fat) needed to be done, BUT...you can't cut forever. I'm afraid they're going to blow it."

Specific problems are mentioned by all respondents. Among these are:

- Annual updates;
- Incentives;
- Frequent changes in the payment rules;
- Outlier payments;
- Payments for patients with multisystem problems;
- Labor market definitions;
- The urban-rural rate differential;
- The lack of community resources;
- Costs imposed on providers by the changes.

Executives and financial officers do not feel that the low annual updates in the PPS payment rates are appropriate or equitable. They feel that the updates should keep up with the rate of inflation. Not to do so removes the incentives for cost control, they feel. "Congress promised that if hospitals did well they could keep the difference as a reward, but they've gone back on their word."

The frequent changes in the various components of the PPS payment structure (one every two months, on average) are also targets for complaints. Information arrives after the effective date so the system is basically retrospective. Executives find it difficult to plan.

Two areas where many feel the system made faulty assumptions are outlier cases and those involving problems with more than one body system. "The DRG program just picks one (system) but these cases are more involved and more costly." For both outliers and multisystem cases, financial officers are uanble to measure true losses because of the lack of accounting systems that report costs per case. Simple comparisons of charges to PPS reimbursement are recognized as being inadequate proof of inequities. However, once new cost accounting is in place, CFOs expect to demonstrate biases.

Two problems relate specifically to the fact that this site is primarily rural. Rural administrators feel they are being unduly penalized by receiving lower base rates and a lower wage index than the two urban hospitals that are only about half an hour away from several of them. "It's unbelievable to me that we are expected to give the same quality of care for hundreds of dollars less," was a typical comment on this.

Respondents at all levels (discharge planners as well as CEOs) are worried about problems arising from earlier discharge. "The cart was put before the horse. There aren't enough community resources to deal with the effects of all this." "Elderly people are falling through the cracks."

Finally, many respondents point out the costs of the changes in the system. These vary from the photocopying for the PRO, to the time required for reports, to the "burn out" of the nurses.

4.0 PPS AND ALTERNATIVE HEALTH PLANS

There is relatively little activity in western North Carolina with respect to alternative health plans such as health maintenance or preferred provider organizations. Consequently, no interviews concentrated on this area. Only two were mentioned in interviews with hospital respondents. One of these was the Blue Cross HMO, which has gained acceptance in market areas containing larger numbers of state employees, for whom it is an insurance option. One regional hospital has also started its own HMO but the HMO is "not likely to succeed," according to an executive in a competing institution. Attitudes toward potential market penetration vary from scepticism to entrepreneurial interest on the part of some physicians and hospital executives. These are discussed in Section 3.1.

5.0 MEDICAL PRACTICE PATTERNS UNDER PPS

5.1 Patterns of Practice

Physicians in western North Carolina practice what many observers would consider "conservative" medicine, particularly in the rural part of this area; lengths of hospital stays tend to be short, averaging less than 6 days per stay in several hospitals. To a degree, this conservatism has been a feature of physician practice for a number of years before PPS. Many doctors in the area are convinced, however, that PPS and the utilization controls imposed through the PRO have had a real impact on practice patterns.

Western North Carolina is an attractive area in which to live and practice, and it has apparently never been as difficult to recruit physicians as in some rural communities. In addition, the state of North Carolina and local philanthropic foundations have spent a considerable amount of time and money to attract physicians from prestigious medical schools, to some communities at least. Other CEOs report they have not known of such a policy. For both these reasons (area attractions and recruitment efforts), new group practices made up of young physicians have moved into the area in recent years, to supplement the older group practices and a sizeable number of solo practitioners.

HMOs and PPOs are virtually nonexistent in this area. Some of the individual physicians interviewed in this site visit are not only cool toward the concept of prepaid health care but also unclear about how the process works. The fee-for-service model is well-entrenched, and likely to remain so for several years but in some counties there has been market entry and even an attempt by the local physicians to start a joint venture with the local hospital.

Physicians in the rural hospitals around Asheville rely on one or both of the large Asheville hospitals for consults and for tertiary care treatment on referral. There is a small amount of inter-hospital consultation and sharing of physician services among rural institutions in specialties such as pathology. Rural physicians rarely have admitting privileges in more than one hospital. When they do, it is almost always in a neighboring rural hospital, rather than one of the Asheville hospitals.

Hospitals in western North Carolina have recruited physicians to protect or expand their markets, although there is considerable variation across hospitals as to which specialties are most needed. Cardiologists, oncologists and ophthalmologists are most often mentioned. However, at least one hospital has studied its local market and concludes that its needs lie in the OB/GYN area. In the last few years, specialties that are entirely new to the area have been added in many of the hospitals. In looking for such specialties as cardiology and ENT, rural hospitals clearly want the patients to stay in town in the early stages of illness, rather than go "over the hill to Asheville."

Physicians and hospitals in the this area coexist in many different ways. In some hospitals, administrators and physicians describe a cooperative model of behavior: confrontations are avoided and shared

goals are stressed. Few hospitals are promoting joint ventures with local doctors, but some now include more physician voting members on their boards of trustees. To some extent, this cooperative approach may reflect individual management style. However, its success is certainly encouraged by low occupancy rates and abundant staff. One administrator notes that when he arrived on the job, he knew immediately that efficiencies could be had, because no physician was complaining about staff shortages.

In other hospitals, physician/administrator confrontation prevails, often transmitted through middle management staff such as DRG and UR coordinators. One coordinator notes that, in her hospital, physicians resist "everything" (as "outside" control of the practice of medicine). Many coordinators and administrators perceive differences between "young" and "old" doctors in reaction to PPS; the latter tend to have relatively more entrenched resistance to PRO standards, criteria and DRG monitoring, resisting the "bureaucratic" controls imposed through rigid admission protocols.

Regardless of whether or not physicians cooperate with or confront hospital administrators over issues of medical management, controls over how physicians practice medicine are, without exception, informal, indirect and generally nonpunitive. As one observer notes, there is a "small town" atmosphere in a rural hospital that precludes doctors taking the review function seriously. On the other hand, many physicians and administrators appear to share a distaste for "outside intervention," in the form of PRO review. Therefore, it is apparently not difficult to convince most of the medical staff that it is in everyone's best interest to understand what the PRO requirements are, and adapt practice patterns at the margin to these requirements.

5.2 Hospital Admissions

Total and Medicare admissions have generally fallen as dramatically in Asheville hospitals since the implementation of PPS as they have elsewhere. Physicians are performing more procedures on an outpatient basis (although several of the Asheville hospitals still use inpatient space for outpatient surgical patients), and some surgery is also performed in physicians' offices. Some physicians perceive an increase in the severity of the average inpatient admission and attribute this to the restrictions imposed by the PRO. Use of social admissions has declined dramatically, to the discomfort of some doctors. One notes that he feels uneasy when administering an enema to an elderly oncological patient who will return, not to a hospital bed but to a local bus for a 50-mile ride home. Many physicians agree, however, that social admissions had been abused in the past.

In addition to an increase in hospital severity, physicians see the decline in admissions affecting:

- overall quality of care: one physician notes that, although the quality of care provided has probably not declined, there may have been some decrease in standards for certain types of cases because they are now in doctors' offices;

- physicians' incomes: both gross and net incomes are seen to be declining, in part because a physician cannot see as many patients in a day in an office setting (in which he/she must provide staff, and equipment support) as in a hospital (in which staff, and equipment support are provided free in most instances).

Although physicians and administrators both point to pre-admission screening and PRO review as factors in the decline of Medicare admissions, many argue that these changes were underway before PPS. For some hospitals, declining admissions are perceived largely as loss of market share and deteriorating competitive position. One rural hospital had responded to a declining census before PPS by launching a major building campaign and adding a richer mix of physician specialties. During the first year of PPS, this hospital increased its admissions, largely by retaining patients who would have gone elsewhere for treatment. Other pressures have also shaped hospital admissions strategies. For example, one hospital administrator notes that his physicians prefer to admit certain cases they know would not pass the PRO's screen, in order to avoid potential malpractice liability.

5.3 Lengths-of-Stay and Post-Hospital Control

Area hospitals' lengths-of-stay were relatively short before PPS; average stays declined further in most hospitals after PPS was implemented. This was due in part both to subtle pressures from administrators and to increased understanding by physicians of appropriate post-hospital options.

As noted earlier, most pressures from UR and DRG coordinators and from colleagues (chiefs of staff, physician advisers) tend to be low-key and informal. DRG information is not generally seen as a useful way to communicate with physicians in most hospitals. In one case, circulation of reports showing DRG-specific charges and payments "alarmed" the medical staff, and administrators decided to cancel the reports. In another hospital, the UR coordinator has attempted to highlight "efficient" medical practice in a positive manner, to counter negative feelings generated by identifying physicians with excessive stays.

Although several administrators complain that the area lacks adequate post-hospital care facilities (particularly nursing home beds), physicians are more aware of existing options because discharge planners, often in cooperation with utilization review staff, have become more active and visible in the last two or three years. In one hospital, the discharge planner worked with the UR coordinator to educate physicians and identify, on her own, cases that require discharge planning. She observes that physicians have grown more accustomed in the last year to requesting discharge planning at admission; the admission form contains a box for the physician to check, indicating levels of post-hospital care that would be required at discharge.

6.0 THE POST-HOSPITAL HEALTHCARE INDUSTRY UNDER PPS

In western North Carolina, post-hospital care is available through a number of sources. There are about twenty nursing homes in the area, most of which provide both skilled and intermediate beds. The demand for beds is such that most nursing homes maintain an occupancy rate of more than 95 percent. Patients for whom Medicare pays account for only about 10-15 percent of the population in the homes visited.

Health professionals also appear to be making increased use of the licensed rest homes in the area for post-hospital care. Individuals are sometimes discharged from the hospital to a rest home, and follow-up health services are provided. Sometimes the rest home is already the patient's residence but it seems that this arrangement is also made when an individual cannot afford recuperative care in a nursing home.

Home health agencies are not nearly as numerous as institutional care facilities. The oldest home health providers in the area are the county health departments which provide skilled Medicare-reimbursable services as well as many other services. In at least two counties, the health department contracts with a local hospital to furnish services through its home care department. In recent years, two proprietary home health agencies have entered the Asheville area market, providing Medicare-reimbursable services as well as homemaker and private duty nursing services. These proprietary agencies bring a sense of competition to the home health field; the territories of these agencies are not bounded by the county lines, as the public agencies are. In addition to these community-based agencies, there is a hospice serving terminally-ill cancer patients.

A number of hospitals also provide the Lifeline program, which makes use of an electronic communication device that can be triggered to signal a receiving station if a medical emergency occurs. This service is growing in popularity, because it enables patients with potentially unstable medical conditions to call quickly for help. It is also useful for patients living in somewhat isolated rural locales.

In addition to these formal services, North Carolina appears to have a well-developed array of community care provided through informal sources such as church groups and other volunteer arrangements. Many respondents mention that formal home health services have had to conquer a specific reluctance among Asheville residents, because families and neighbors strongly prefer to "take care of their own," and hesitate to accept assistance, even though an individual may require skilled care. Even institutional placement is refused occasionally, because the family desires to care for the patient at home. One home health director described a recent case in which a terminally ill man was cared for at home, by volunteers, 24 hours a day.

This tight family environment is lacking, however, for increasing numbers of older, retired individuals who are taking up residence in the Asheville area. These people are unlikely to have younger friends or relatives nearby to assist them. With these changes taking place in the population, it is likely that the demand for community-based care will continue to increase.

Another factor influencing the environment in western North Carolina is common among rural populations: people are well known to each other. One respondent, commenting on the care patients receive in the hospital, notes that every person admitted is very likely to be related to at least one staff person. This may change as retirees settle here, but in the meantime it sets a tone for all providers not to change standard practices too rapidly because family members are on hand as advocates.

6.1 Hospital Involvement in Post-Hospital Care

Hospitals in western North Carolina are becoming more involved in post-hospital care. Of the eight hospitals in the case study, two currently offer home care services and one has an extended care facility. At the time of the visit, a few other hospitals reported that they were considering the development of both institutional and community-based care.

The current configuration of the home health industry may be one reason that more hospitals are not moving more aggressively into development of home health services. Since most agencies are public county facilities, and most of the hospitals are either the only one or one of only two in the county, the hospital executive staffs may reason that they have adequate access to home care and can avoid the investment and start-up problems that must be addressed if they establish their own departments.

In terms of institutional care, the area hospitals are interested in developing extended care beds, however. The North Carolina CON process has limited expansion of such beds for a number of years and has recently agreed to approve the establishment of 60 new beds. Who will win the CON is a matter of much interest to the health care community. Several organizations that provide long term care are applying for the beds, as are at least two hospitals. Both types of facilities believe that whoever wins the CON will have gained an edge in the struggle that goes on over placement of patients. The private nursing home administrators believe that if a hospital gets approval, the discharge planners will refer only the most difficult patients to the other facilities. The hospitals believe that if one of the present facilities gets the beds, they will be quickly filled with patients who have "lighter" care needs, and the difficult-to-place "heavy care" patients requiring intensive care will continue to be avoided.

6.2 Hospital Discharge Planning

All eight participating hospitals furnish discharge planning services for patients. In all eight, the primary responsibility for this function is held by the Social Work Department, and in seven, it is considered the major focus of their work. In one hospital, however, the function of discharge planning appears to be just one of a number of functions of the hospital social worker. Nurses are beginning to share discharge planning responsibilities in several of the hospitals. In one

With the establishment of proprietary agencies, there is a growing competition among the home health agencies. The proprietaries are the only agencies not bounded by county lines. The county agencies are therefore considering (for the first time) strategies or improve their market shares.

Among the agencies visited, there are no consistent patterns of changes in utilization since PPS was instituted. Two agencies that have grown attribute some of the growth in referrals to the advent of PPS, but also point to the expansion of services and successful marketing as reasons for growth. Another agency director reports that referrals have actually dipped slightly (she speculates that this is related to the decrease in admissions to the local hospital and to fewer referrals from physicians' offices) but the number of visits has increased by 60 percent. She believes this to be an indication of the increasing debility of patients discharged from hospital.

All directors think that patients are sicker now than before the institution of PPS, although the extent of how much sicker is not agreed upon. One director of a hospital-based agency thinks that patients are not much sicker, and that although high-tech nursing is available, it is not required all that much. Another agency administrator reports that there have been significant changes in services. This director believes that there have been increased referrals from emergency rooms, now that social admissions are no longer feasible, and that there has been a dramatic increase in orders for IV therapy at home.

All agency directors report that their agencies have changed in response to changing needs. One hospital-based agency director requires home care nurses to work on the acute unit for one shift a week. Other directors are hiring nurses with ICU and acute care experience. Home health aides are regularly available seven days a week now - since sicker patients need weekend care. One agency has added a staff member to administer the weekend workload. All agencies report increased demand for physical therapy, explaining that hospitals now discharge patients before PT can be furnished. Another aspect that has changed is the area of teaching: hospital staff are not teaching patients and family about medications, protheses, etc., before discharge, so the home health staff must do more.

All of the directors report that they feel they have a positive working relationship with their current intermediary. The state home health association has established an Intermediary Relationship Committee that meets bimonthly with intermediary representatives to discuss issues. Directors believe this is very useful, but also express frustrations regarding recent "tightening up" of claims review by the intermediary. They express concern that reviewers are not familiar with the home health field, and this results in requirements for extensive documentation and in denials based on inconsistent interpretation of regulations. In addition, all report that a policy of increased stringency is being followed, and that home health directors, in the face of it, have become more conservative. Instead of risking confrontation regarding the validity of a service, they seek out other payment sources

(county funds, grant monies, etc.) They note that while the casemix has changed, and patients need more care, Medicare is withdrawing from its provision of that care.

6.5 Nursing Home Administration

Three nursing homes participated in the North Carolina case study. Two are located in the urban area while the third is some distance away. All three have occupancy rates close to 98 percent, with the Medicare share being between 10 and 15 percent. In two of the homes, Medicaid-eligible residents make up 50 percent of the census while the third home is primarily private-pay. The Medicare share has dropped off in recent years. One director notes that a year and a half ago the Medicare share commonly had been about 16%, but it is now 10 percent. Another reports that the Medicare census has dropped from 27 to 12 in the same period.

All three nursing homes report that the patients being referred from hospitals are sicker than they were prior to PPS. One director comments that some patients are barely stable medically and that about two patients a month (out of 20 admissions) are returned immediately to the hospital. All three directors note that there has been an increase in the number of patients who require IVs, TNT needles, and naso-gastro tubes, who have decubiti, and who are total care patients. For example in one nursing home, 15 percent of the current census were dependent on tube feeding. Another director comments that patients with good rehabilitation potential are not being referred to nursing homes, but are going home with home health services.

The nursing home administrators have responded to this increase in medical and nursing needs of referrals by up-grading staff; for example, an RN may be hired for a position formerly held by an LPN, or an LPN may replace an aide. One home has added a ward clerk, to take some of the clerical workload off the nursing staff. Another step that managements have taken is to control the mix of cases. For example, because tube feedings can only be done by licensed personnel, admissions of patients requiring tube feedings are limited, so as not to stretch licensed personnel time.

There is general consensus that the relationship with discharge planners has shifted in recent years. Administrators feel they are being pressured to accept patients who are sicker than in the past. The discharge planners are more aggressive in seeking placements for the hard-to-place; but they are also initiating plans earlier than they had. One director believes that some of the perceived lack of beds is really due to the discharge planners' increased case loads; they are under so much pressure that frequently they do not have time to complete the planning process.

7.0 PROGRAM OPERATIONS

7.1 Peer Review Organization

7.1.1 Administration

The North Carolina PRO, Medical Review of North Carolina (MRNC), was formed by a coalition of eight PSROs. The Asheville PRO operates through a subcontract with MRNC. It is a former physician-sponsored PSRO, founded in 1978. It conforms to state procedures determined by MRNC.

In addition to its Medicare contract, MRNC also has contracts with private industry; the state, to review health care services provided in its prison system; and with the state Medicaid industry. At the time of the site visit, about 500 (14% of the state's total) physicians were participating in the Medicare review process. The PRO reports that it has difficulty only in attracting the most highly specialized physicians to participate in the review process. Under the current contract, MRNC reviews 27 percent of all Medicare claims statewide. Under the new contract, 45 percent of all record reviews are being referred to physician reviewers.

MRNC staff and the hospitals appear to maintain good working relationships. A Memo of Understanding between the MRNC and the hospitals is endorsed by the state hospital association. A PRO contact person, generally the administrator or assistant administrator, is identified at each hospital and receives all correspondence. The review team offers exit interviews as well as leaving written documentation on every case reviewed.

Each hospital receives a manual explaining the PRO procedures, details of sampling, and the criteria used in review. Monthly updates and bulletins about specific actions are sent to the PRO contacts. Last year, MRNC offered workshops about each change in procedure or activity. Now, because of the large budget cuts, the PRO does not have time. Also, they find the written communications have been more useful to providers.

One factor with a negative effect on relationships with providers is the PRO's lack of capacity to pay for copying records. As noted above, almost half of all records reviewed are referred for physician review and therefore must be copied.

The PRO is also accessible to beneficiaries. The MRNC has publicized its existence, and now receives about 100 calls monthly from beneficiaries, mostly regarding pre-admission reviews. Most can be dealt with by providing more information regarding the regulations. Since inception, it has looked into about 100 complaints, including ones from Congressional offices. About 5 percent had some validity, according to the MRNC director.

7.1.2 SuperPRO Ratings and HCFA contracting

In Cycle I of the SuperPRO activities, this PRO rated just about average for DRG validation, admission referral reviews and medical necessity reviews. In the area of quality reviews, the SuperPRO found 4.9 percent problem cases; this was higher than the national average of 3 percent.

In the first contract, MRNC successfully met all its objectives. In terms of total utilization, HCFA estimated that admissions could be reduced to 313,000 for 1984-1985; actual admissions for that period were 250,000. There have been major practice pattern changes. For example, 90 percent of cataract procedures had been done on an in-patient basis. This has now decreased to 25 percent.

In its first contract, MRNC had a non-mandated objective to decrease unnecessary one- and two-day stays. It reviewed every stay of that type during the contract period, and began to push the hospitals develop out-patient care and observation beds. This strategy has been successful; a number of hospitals have established 23-hour observation units. The PRO is continuing to track brief stays under the new contract.

Although, under the terms of the new contract, MRNC could have reduced its reviews to only the five mandated, it has chosen to continue with its full complement. The director and board believe that physicians have become accustomed to the review process and want to maintain its impact. It should be noted that, in the new contract, payment has been reduced by one million dollars. In response, MRNC is trying to cut expenses, such as office rental costs, and has reduced staff. The director reports that the reduction in payment is a serious blow, and that it is a sign of the Board's commitment to quality of care issues that the agency is able to function.

7.1.3 Quality Assurance and Record Reviews

The review process is as follows. A sample of records is pulled from the fiscal intermediary tape of claims. Although the eastern part of the state uses RNs as reviewers, the western part has a staff consisting of a registered record administrator, an accredited record technician, a licensed practical nurse, and one non-credentialed staff person. These four review and certify the records, using criteria developed by PRO physicians. All first-line review takes place on site. The staff identify problem cases for physician review. If there continues to be a question, that physician will write to the attending physician and hospital with questions. The response is reviewed by a second M.D. and a decision made. If the attending disagrees with the finding, there is an opportunity to discuss the case by phone with another physician reviewer.

A formal appeals process exists. The physician makes a formal request for the record to be reviewed again. This review is by a physician matched in specialty and Board-certified. About 210 cases are appealed each month; about 50 percent of the appeals are upheld. Since the PRO's inception, only twelve cases have gone to an administrative law judge, the final level of appeal.

For quality assurance and productivity, this PRO has developed procedures used at all sites. Each on-site reviewer records the number and types of records reviewed on a daily time sheet. The productivity standard is three cases per hour. The monitoring plan to provide quality assurance requires a sample from each sub-area each quarter for re-review. Each physician reviewer is monitored in the same way.

Although this PRO has met all its objectives, its denial rates are low across all objectives. Every objective yields some denials, however. MRNC believes that the sentinel effect has been the major influence of the PRO. After a few months of 10 percent denials, both utilization and denial rates plummeted and have remained down. MRNC believes that HCFA's emphasis on denials is misplaced. The director points to the effects on practice patterns - the shift in location for cataract surgery, the development of observation beds, the decline in short stays - as evidence of success.

Denial rates do not cluster around any specific reviews, according to MRNC analysis. Instead, denials are reportedly more associated with specific hospitals and physicians. MRNC speculates that hospitals have handled the transition to PPS differently; some have taken longer than others to install monitoring processes and to offer education and information. As hospitals develop these measures, denial rates improve.

In terms of quality, MRNC reports that they expected far more problems than have actually been seen. They do find a correlation between DRG validation problems and quality problems. So far, however, none of their analyses show clustering around any factor other than specific physicians. MRNC has established a detailed Quality Review Protocol which has identified numerical thresholds for intervention for both physicians and providers with identified quality problems. The numerical thresholds are established both in terms of problems identified during three consecutive months and cumlatively. When a threshold is reached, the cases involved are referred to a Quality Review Panel for re-evaluation. If the Panel concurs with the decisions of the phsycian reviewers, two options are available. Depending upon the severity of the confirmed problmes, the Panel may initiate formal sanction proceedings or may direct MRNC's staff to select 100 percent of the cases for review for a period of time the Panel determines as appropriate.

7.2 Fiscal Intermediary

Blue Cross of North Carolina is the fiscal intermediary (FI) for most important Medicare claims and for nursing homes' and home health agencies' (HHAs) claims. The home health agencies, however, are moving to Blue Cross of South Carolina at the end of their current fiscal years. Of approximately 100 HHAs, 15 were to have moved by the end of December, 1986.

This FI has automated the receipt of over 90 percent of its hospital claims. Non-hospital providers are not automated, so the overall rate is somewhat over 80 percent of all claims. Five to six thousand claims are processed daily. Edits in the hospital have sped up the process. For example, a PPS hospital is not to send a bill for a claim unless it covers the complete admission to discharge stay.

Ten percent of claims are still "suspended" by the computers as having an error but only five percent or less require contact with the hospital. One of the more common reasons for contacting the hospital is a problem with a patient's eligibility. Often this is the minor problem of a mismatch on Medicare's HIC number. Sometimes there is a problem as to whether the patient is eligible for coverage on a days basis. The average processing time for a hospital claim is 7 to 8 calendar days, half of which is the time needed for a response from HCFA on the patient's eligibility.

For non-hospital providers, SNFs make up a very low percentage of claims because "the industry shies away from Medicare patients." Most home health agencies are reportedly a month or more behind in their own transmission of claims and the lack of automation means that settlement is far slower than for hospitals. Out of 120,000 monthly claims, three to four thousand are ultimately denied, about half because the service provided is "non-medical."

The FI reports that, in general, hospitals in North Carolina have "fared well" under PPS. Most hospitals reportedly do not know what their rates are. FI representatives suggest that county-owned hospitals are subsidized and so do not "need to worry about losses as much." However, there are many factors affecting the state's hospital industry, especially those in rural areas. Regional centers have reportedly reorganized and some rural facilities have recently been sold to chains or become managed by them.

The major complaint of hospitals with the FI (reported at the FI) are disputes as to what were the correct numbers on which the hospital specific rate is based. The FI representative feels that the "base year was an unusual year" and the system should be rebased. Other complaints could include the fact that the MCRs are getting larger (an irony of prospective payment to the respondents), and that there are delays in cost-based payments to hospitals, due to the difficulties the FI has in keeping up with HCFA's changes.

7.2.1 PIP and CPEP

In North Carolina virtually no providers are on PIP. The electronic processing of claims is so fast that PIP is seen as a poor alternative. In fact, none of the providers interviewed by the site team was on PIP.

Bigger problems for this FI center on the Medicare Return Ratio of $5 in savings for every $1 of administrative cost. This ratio is very hard to meet. The FI does no medical reviews on hospitals. Nursing homes are a very small percent of claims and so do not represent good targets for savings. HHA denials do not represent large dollar amounts and, in addition, hospital-based agencies are billing their services as Medicare Part B so this FI does not handle them.

This FI is also in several disputes with HCFA over its own budget. In fiscal 1985, there were ten budget revisions and payments reportedly fell short of costs by about $300,000, in part because of the budget costs, but also because the FI processed more claims than its set workload. This dispute may be settled in court. For fiscal 1986, there were 13 budget revisions but the FI finished the year only $19,000 over its budget. For FY87, the funding is reportedly at the requested level.

7.2.2 HHAs and Record Review

For home health agencies, 80 percent of claims are reviewed, including 100 percent of those on North Carolina's 485 and 486 forms. (These forms reportedly are often not filled out correctly and do not speed up processing.) Only about 5 percent of the reviewed claims are

ultimately denied. Very few HHAs have been taken off their waivers of liability. Problem agencies across the state have included large agencies, and those duplicating claims (particularly for physical therapy) with SNFs. The largest categories of care that are denied include observation and evaluation, decubitus care, dressing changes, and teaching patients or their families. Teaching is paid for only for the first two to three months after discharge, depending on the complexity of the type of care the patient or family must perform.

Some definitions that create the most confusion for providers are:

- Intermittent Care
- Daily care
- Homebound Status
- Skilled Home Care

Intermittent care refers to a "medically predictable recurring need for care at least once every 60 days." Care given two or three times a week is the most common category of intermittent care. Daily care is anything given five days a week and may vary between one and five visits a day. The daily care rate is reportedly limited to the first three weeks after discharge but can be extended if the need exists.

Homebound status is hard to define. Formally it refers to those who cannot leave home, because of a medical condition, to receive medical care. Representatives of the FI suspect that the actual restrictions are not always for medical reasons but are due to difficulties of transportation or other social reasons.

The issue of skilled care is also a problem. Skilled care refers to the need to have an RN or RN supervisor (someone with special medical knowledge and the ability to judge a medical situation) examine the patient. This is felt to imply an unstable medical situation. Taking blood pressures, giving enemas, or changing dressings are judged not to be skilled care.

FI representatives feel that the impact of PPS has been to discharge patients quicker and sicker. They see an increase in HHA claims and a trend toward more intensive home care (e.g., hyperalimentation, IVs, etc.). "People should be in SNFs but SNFs won't take them because they need too much care. There's something wrong there somewhere."

CMS LIBRARY
3 8095 00013567 9